



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Consultants in Pain Medicine

Respondent Name

St Paul Fire & Marine Insurance Co

MFDR Tracking Number

M4-17-2544-01

Carrier's Austin Representative

Box Number 5

MFDR Date Received

April 26, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In review of your explanation of benefits, it seems that you denied code 80307 and G0480. We feel this was denied in error. All the required information was submitted for the lab testing that performed as set forth by the Texas Administrative Code."

Amount in Dispute: \$98.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider alleges they are entitled to reimbursement for the services at issue. The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the services in dispute are included in the Medicare base rate for CPT code G0480 reimbursed under this date of service. The Carrier contends the Provider is not entitled to additional reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2017	80307	\$98.85	\$76.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the medical fee guideline for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

- 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
- P12 – Workers’ compensation jurisdictional fee schedule adjustment
- 309 – The charge for this procedure exceeds the fee schedule allowance
- T161 – For payment please provide the drug screen or lab test results
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- W3 – Additional payment made on appeal/reconsideration
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted
- 6578 – Individual laboratory codes which are part of a more comprehensive laboratory panel code were reimbursed at an all-inclusive panel code. All other drug screen codes are included in the reimbursement for the comprehensive laboratory code
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code

Issues

1. Are the insurance carrier’s denials supported?
2. What is the rule that applies to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for services provided on February 6, 2017 in the amount of \$98.85 for the following:

Procedure Code 80307 – “Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.”

The insurance carrier denied disputed services initially with adjustment reason code 16 – “Claim/service lacks information which is needed for adjudication.” A second explanation of benefits indicates 97 – “Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated” and 6578 – “Individual laboratory codes which are part of a more comprehensive laboratory panel code were reimbursed at an all-inclusive panel code. All other drug screen codes are included in the reimbursement for the comprehensive laboratory code.”

Review of Chapter 10, of the 2017 National Correct Coding Initiative Policy Manual, found at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> in Section “E” Drug Testing finds,

*Beginning January 1, 2017, urine drug **presumptive** testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.*

*Beginning January 1, 2016, urine drug **definitive** testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this code range may be reported per date of service.*

Therefore the Division finds the carrier's denial is not supported. The maximum allowable reimbursement will be calculated per applicable fee guidelines discussed below.

2. 28 Texas Administrative Code §134.203 (e) states,

The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

- (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,
- (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

Review of the 2017 Clinical Diagnostic Laboratory Fee Schedule finds no separate allowance for the professional component. Therefore the maximum allowable reimbursement will be calculated per 28 Texas Administrative Code 134.203(e)(1).

The fee schedule amount found in 2017 Clinical Fee Schedule at www.cms.gov for code 80307 is \$61.02. This amount multiplied by 125% = MAR of \$76.28.

The total allowable is \$76.28. This amount recommended.

3. Based on requirements of 28 Texas Administrative Code §134.203 the amount payable is \$76.28. The carrier previously paid \$0.00. The remaining balance of \$76.28 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$76.28.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$76.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ May 19, 2017 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.